Department of Health and Human Services Auditing Functions
OPEGA Summary for the Government Oversight Committee
Updated for April 12, 2013

Department of Health & Human Services - Division of Audit

The Division of Audit is part of the Financial Management Services within the Department of Health and Human Services. Financial Management is responsible for managing the resources entrusted to the Department in an efficient and effective manner. The Division of Audit is comprised of five units. Table 1 is a summary of each unit's activities and staffing levels.

Table 1. DHHS Audit Units – Staffing and 2012 Activity

Unit	Brief Description	Staff[1]	2012 Activity	Over/Underpayments, Recoupments, Prosecutions
MaineCare Cost Settlement	Conducts cost settlement reviews on MaineCare providers receiving reimbursement on a cost basis such as Nursing Facilities, Hospitals, Residential Care Facilities, Private Non-Medical Institutions and Intermediate Care Facilities for the Mentally Retarded (ICF/MR)	1 Manager 16 Auditors (I-III) – (1 vacancy)	355 Audits	$7.1M over / $5.6M underpayments identified
Social Services	Conducts desk reviews on A-133 audits submitted by community agencies as well as close-out reviews on all Department contracts to sub-recipients	1 Manager 5 Auditors (II-III)	240 Examinations	$1.9M recovered
Program Integrity	Monitors payments under MaineCare for non-cost settled programs, conducts post payment reviews to prevent/limit fraud abuse and waste	1 Manager 14 Staff[2] – (4 vacancies)	190 Recoupment Letters	$16.7M recovered
Fraud Investigation & Recovery	Investigate frauds, attempted fraud, commingling or misapplication of funds administered by DHHS	1 Manager 17 Fraud Investigators – (10 vacancies)[3] 2 Office Associate II – (2 vacancies) 1 Office Assistant II –	2028 cases opened 778 cases closed	31 individuals 60 crimes 57 pending prosecutions
Internal Audit	Oversees all auditing of DHHS conducted by external agencies, assures corrective action plans are implemented and meeting their objective and conducts specialized audits as needed	1 Manager 1 Auditor II		
Source: Power Point presentation prepared by DHHS for the Joint Standing Committee on Health and Human Services				

[1] Each unit is overseen by a "Program Audit Manager" who, according to the job specifications, needs to be either a Certified Public Accountant or a Certified Internal Auditor. The other positions in all of the units require varying levels of experience and education in fields such as accounting, business administration and auditing but do not required certification in these fields.

[2] Staff positions include: 2 Comprehensive Health Planner II; 4 Comprehensive Health Planner I (3 vacancies); 4 Auditor II; 1 Management Analyst II (vacancy); 1 Planning & Research Associate; 1 Medical Surv. & Utilization Supervisor; 1 Office Associate II

[3] Eight of the vacant Fraud Investigator positions and both vacant Office Associate II positions were just recently created.

DHHS Division of Audit: Program Unit Descriptions[4]

MaineCare Cost Settlement

The MaineCare audit section conducts compliance audits and issues final cost settlements on all MaineCare cost reimbursed programs. These programs include Nursing Facilities, Intermediate Care Facilities for the Mentally Retarded, Residential Care Facilities, Private Non-Medical Institutions, Day Habilitation Services and Hospitals. These audits are conducted to ensure that MaineCare funds are expended in accordance with the MaineCare Benefits Manual, the Provider Reimbursement Manual, and the Code of Federal Regulations. This Unit processes over 600 cost reports representing approximately $1 billion in MaineCare funding annually.

Social Services

The Social Service unit of the Division of Audit has oversight responsibilities for State and Federal grants that pass through the Department to community agencies. Part of these oversight duties includes advising community agencies, Independent Public Accountants (IPA) and Department grant administrators of the requirements imposed on grant dollars by existing State and/or Federal legislation, statutes and regulations.

Community agencies that receive state and/or federal pass through funds must comply with the requirements of the Maine Uniform Accounting and Auditing Practices for Community Agencies (MAAP). One of those requirements is for agencies that expend $500,000 or more of state or federal pass through funds to have an audit performed by an Independent Public Accountant. Agencies expending $500,000 or more of federal funds in a fiscal year, must also meet the audit requirements of Federal Circular OMB A-133 (Single Audit) and the Social Services unit ensures agencies comply with those requirements. The Unit has the responsibility of issuing a management decision on the findings and corrective action plan that result from a single audit of a community agency as to what corrective action is necessary.

At the end of a community agency's fiscal year Social Services performs an examination/review of an agency's records to ensure compliance with applicable State and/or Federal legislation, statutes and regulations.

Internal Audit

Internal Audit (IA) is responsible for monitoring all audits completed on the Department of Health and Human Services (DHHS). This includes the A-133 financial audit conducted by the State Department of Audit as well as compliance audits conducted by the various Federal Agencies which fund DHHS programs.

Other areas of responsibility of IA include:

- Act as a liaison between DHHS program management and audit agencies ensuring audit related questions are fully responded to in a timely manner.
- Review corrective action plans and helps formulate DHHS responses to audit findings.
- Assist in the implementation of internal controls to correct deficiencies identified in audit findings.
- Monitor the effectiveness of controls and recommend changes as necessary.

[4] The information provided in this summary was obtained from DHHS' website or other public documents prepared by the Department.

- Conduct audits and reviews within the Department as directed by the DHHS Audit Committee.

Program Integrity

Program Integrity (PI) is responsible for monitoring and safeguarding the MaineCare Program against fraud, abuse and waste. It conducts analysis of MaineCare billings to detect utilization patterns or trends that may indicate fraud, abuse or waste. Based on data analysis or referrals/complaints received from other State agencies, health care providers or members, PI may perform retrospective audits/reviews of MaineCare Providers and members to validate the allegations of fraud, abuse or waste.

Fraud, Investigation and Recovery Unit (FIRU)

The Fraud, Investigation and Recovery Unit (FIRU) is authorized under 22 MRSA § 13 to investigate fraud, attempted fraud, commingling or misapplication of funds administered by the Department of Health and Human Services. Reports of potential fraud and abuse may be referred to FIRU by other State departments, political subdivisions and the public. In 2011, the unit was equipped with a Fraud Hotline with state-wide toll free access and a general fraud reporting email. Fraud may also be reported to the unit through an online form maintained by the Department. FIRU investigates more than 3,000 allegations per year.

FIRU is also responsible for the recovery of established improper payments in TANF, Food Supplement Program (Food Stamps), Medicaid and the General Assistance programs pursuant to 22 MRSA 3811 et al and promulgated in the Fraud Investigation and Recovery Manual.

OPEGA Questions & Responses Received from DHHS Division of Audit

1. Are there audit units in any of the respective DHHS Offices? If so, how do they coordinate with your Division?

   There are no other audit units in the DHHS Offices that we are aware of. We do have investigators from the FIRU located in the regional offices but they are all considered part of the Division of Audit.

2. Are there sub-units to any of the identified 5 units in the Division of Audit?

   Currently there are no sub-units within the 5 units of the Division of Audit. We are looking into restructuring the FIRU to set up a unit for legal/criminal investigations and general investigations. The legal/criminal group would work with the AG's office on preparing cases for prosecution. The general investigators would work with eligibility specialists to prevent unqualified applicants from receiving benefits and to identify recipients currently receiving benefits that should be removed from the system. We are also looking at reorganizing the PI unit to have a group that would focus only on data mining and a group that would conduct audits.

3. The presentation OPEGA reviewed states that DHHS is required to have three of the units. What rule(s) or agencies, State or Federal, require them?

   The MaineCare Cost Settlement Unit is required under 42 CFR §447.202 and MaineCare Benefits Manual chapter III sections 45, 50, 67 and 97. Additionally Department rule 10-144 chapter 115 requires this unit. Program Integrity is required by 42 CFR §455.14 and §456.22 and MaineCare Benefits Manual Chapter 1. MRSA Title 22 §13 authorizes the Commissioner to establish a Fraud Investigation Unit within the Department. The Social Service unit is required under OMB circular A-133 and MRSA title 5 §148-C.

4. How do you select what to audit in the MaineCare Cost Settlement Unit and Social Service Unit? Is there a target number each year?

   The MaineCare Cost Settlement Unit audits cost reports submitted by providers. All cost reports have to be audited. We try to annually do at least one year's worth of cost reports which would be approximately 430 plus 10% more to reduce any backlog. The Social Service Unit must audit every Agency receiving over $500,000 in funding. This is approximately 114 Agencies. All Agencies with less than $500,000 fall into a risk pool. The Division of Audit's goal is to examine one-third of the risk pool each year.

5. How many cases in the Fraud Investigation and Recovery Unit were initiated by:
   a. complaints – hotline/web reporting; 1782
   b. referrals from eligibility specialists; 188
   c. front end detection work; 14
   d. legal; 32 individuals, 60 crimes

6. How many cases in the Program Integrity Unit were initiated by
    a. Complaints; 36
    b. Referrals from State or Federal agencies; 27 (includes global cases as they are referred by MFCU)
    c. Global cases (and which ones if available)
    d. Exception Reporting using SURS
    e. Review of MaineCare policy sections; 477 (includes exception reporting as these are not broken out in our data)

Additional Information Requested by GOC Members on 3-8-13

1. Summary of Current & Historical Staffing Levels
    - As can be seen on the attached organization chart, not all positions within the Division of Audit are auditor positions. Other job classifications include Audit Program Manager, Comprehensive Health Planners I and II and the Fraud Investigators in the Fraud Investigation Unit. Because of the diversity of job classifications within the Division as well as how changes to individual positions are tracked, OPEGA was unable to definitively determine the historical staffing levels for the DHHS Auditing functions and impetus for changes in those levels.
    - There are currently 26 Auditor positions within DHHS (Auditor I, Auditor II and Auditor III positions). Since 1995, 13 like positions have been eliminated (see attachment). Nine of these positions were eliminated between 1995 and 1996; the remaining four positions were added in October of 2007 and eliminated nine months later in June of 2006.
    - In regard to hiring status, all vacant positions on the attached organizational chart are in the active hiring process, or have been recently filled, with the exception of the two positions highlighted in yellow. One of these positions was an incentive retirement and will not be able to be filled until June 15, 2013. The other position has approval to be open for hire but there is a pending grievance and, until resolved, the position will not be posted. No new positions are being requested.

2. What is DHHS currently doing for analytics?

    Staff currently has four different tools to access claims data for analysis in the detection of fraud, waste and abuse. OPEGA notes that these analytics are reactionary or retrospective in nature and that the Unit is not performing proactive data mining. Two of the tools are for older data and two are for the more recent MIHMS data. Of the two used to analyze MIHMS data, one examines claims data. The other (JSURS) is capable of drilling down into the data and generating reports in response to specific data queries. DHHS is less satisfied with this tool. The Audit Division is in the process of working with the vendor to address several shortcomings and provide additional training to Audit Division personnel. To better utilize this data tool, the Department plans to hire a staff person dedicated to working with it.

3. GOC members have heard that the department is disappointed in the new software DHHS obtained. Can you explain why? OPEGA received the following response from DHHS:

    The JSURS tool has some strengths like the drilldown capabilities described above. However some of its shortcomings are:

    a. There are no canned queries that are based on the specific logic required to identify basic coding and billing errors (dupes, NCCI, MUEs)

b. Getting comparison analyses (peer to peer reviews), high level summary analyses, averages analyses and outlier analyses is a convoluted, multi-stepped process and seems more difficult than it needs to be.
c. Currently, getting the data to the levels described, staff spends an inordinate amount of time transferring and working the data in Excel or Access dbase.
d. The system sometimes has performance issues – speed of processing and limited number of queries that can be executed at one time.
e. Basic drilldown functionality does not allow for saving the logic. For each query, the logic in the report set up must be recreated. Not very efficient.
f. Drilldown claims return is limited to 50,000 lines. We review claims data for up to 5 years and for many providers the return is millions of claims. Staff must run numerous queries with limited timeframes so as to not exceed the 50,000 line limit.

As noted above, the Division of Audit is working with the Vendor to address these shortcomings and the Vendor has agreed to have their staff person come in and work on writing algorithms. The Vendor will provide additional training to staff working on the system. The Division of Audit is looking at ways to maximize the speed of processing queries and will be hiring a staff person dedicated to working with the tool to take advantage of its capabilities.